Introduction to Bayou Health Louisiana's Coordinated Care Model for Medicaid and LaCHIP Recipients

A Resource Guide for Pharmacists

October 2012

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Overview

Through Bayou Health, the Department of Health and Hospitals (DHH) has transformed the way health care services are delivered to Louisiana's Medicaid and LaCHIP (Louisiana Children's Health Insurance Program) recipients. In 2012, Louisiana Medicaid/LaCHIP moved away from the legacy Medicaid fee-for-service care system and into a coordinated model of care.

The coordinated care models, compared to the legacy Medicaid fee-for-service care model, are designed to provide better health outcomes for Louisiana residents, including a stronger focus on coordination of health care, managing chronic conditions and diseases, and encouraging healthy behaviors. This is an important change that will improve the health and lead to greater quality of life for more than 895,000 Louisiana citizens enrolled in our Medicaid and LaCHIP programs.

The conversion from our fee-for-service system to the managed care model includes two central processes. The first is the process of providers deciding which health plans to join. The second is the process of Medicaid/LaCHIP recipients choosing a health plan that will be responsible for the coordination and delivery of their health care services.

The startup of Bayou Health began in February 2012 for the parishes in the New Orleans and Northshore areas. Parishes in South Central Louisiana, Capital Area, and Acadiana transitioned to Bayou Health in April 2012. Parishes in Southwest, Central, and North Louisiana transitioned to Bayou Health in June 2012, which marked the statewide implementation of this new managed care model.

This guide includes updated general information about Bayou Health from *The Bayou Health Plan Choice Process for Medicaid and LaCHIP Recipients,* A Resource Guide for Providers that was originally made available by DHH to providers in December 2011, to help them prepare for the transition. This guide also includes new information for pharmacists that is specifically focused on the Bayou Health "carve in" of pharmacy services that begins November 1, 2012.

The general Bayou Health information includes a description of all Medicaid and LaCHIP recipients who will be included in Bayou Health; a listing of service carve outs from Bayou Health; dos and don'ts guidance from DHH for providers regarding the recipient choice process; and a list of answers to frequently asked questions.

Pharmacy-specific information includes summary descriptions of key Bayou Health pharmacy policies and practical information for pharmacists that will help facilitate the "carve in" of pharmacy services.

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I. THE GOAL OF BAYOU HEALTH

Bayou Health is based on the premise that we are "first and foremost" committed to improving the health of our recipients by giving them the ability to choose their health care options. Several key elements are at the core of our mission:

- Better quality of care and improved health outcomes through a focus on prevention, better coordination of care, interventions to actively manage chronic illnesses, and a comprehensive patient-centered medical home.
- Increased access to care, including enforceable time and distance requirements, negotiated rates with specialists, and the ability of the prepaid plans to contract with providers currently unwilling to enroll in Louisiana Medicaid.

This system will allow extended benefits for our recipients and/or incentives for recipients who comply with care recommendations and incentives for healthy behaviors.

The success of Bayou Health will be measured by specifically comparing key health indicators against the current delivery system, including:

- Reduction in avoidable hospitalizations
- Reduction in hospital readmissions
- Reduction in preterm births and neonatal costs
- Reduction in emergency room costs
- Reduction in duplicative services
- Improved outcomes through early detection and treatment

The overriding goal of Bayou Health is to encourage recipients to actively participate in their own health and the health of their families. It is a message of empowerment that seeks to motivate Louisianans to make healthier choices for themselves and their families. This will start by ensuring that our recipients have a choice in their health care delivery system. The following five statewide health plans are available through Bayou Health:

- Amerigroup
- Community Health Solutions
- LaCare
- Louisiana Healthcare Connections
- UnitedHealthcare Community Plan

These plans differ from one another in several ways, including their provider networks, referral policies, health management programs, and extra services and incentives offered. Each of these plans is accountable to DHH and the state of Louisiana. Each contract requires adherence to detailed grievance and appeals requirements. Members have the right to appeal, first to their Bayou Health plan, then to the state.

There are also strict marketing and recipient outreach guidelines that each plan must adhere to with mandatory prior approval by DHH of marketing materials. DHH monitors all complaints, grievances, and appeals to ensure the system is accountable to the recipients and the state.

The state expects quality will improve for both Medicaid and LaCHIP populations. Incentives and disincentives are tied to performance and to meeting quality goals. DHH is using 37 health care quality improvement measures to track performance, and will publicly post quality report cards for each Bayou Health plan.

II. BAYOU HEALTH: Included and Excluded Medicaid and LaCHIP Recipients

Most, but not all Medicaid/LaCHIP recipients chose a health plan between December 2011 and May 2012. In that short period of time, over 895,000 of Louisiana's current 1.2 million Medicaid recipients became part of Bayou Health. Some recipients had the option to choose a health plan or keep their current Medicaid coverage, and some recipients were excluded from Bayou Health and remain excluded at this time.

Health Plan Choice Required (unless a member of an excluded population)

Medicaid and LaCHIP recipients under age 19

Eligible parents of Medicaid recipients under age 19

Pregnant women except those enrolled in LaHIPP

Enrollees who receive Medicaid because of age, disability or blindness

Health Plan Choice Optional

Children under the age of 19 who receive SSI or Family Opportunity Act

Children under the age 19 who are in foster care

Children under the age 19 who are in juvenile justice custody

Children under age 19 receiving services through OPH Children's Special Health Clinics

Native Americans

Excluded from Bayou Health

Residents of a long-term care or DD facility

Medicare recipients

Individuals enrolled in a Home and Community Based Waiver or age 3 through 20 and on waiting list for NOW or Children's Choice Waiver

Louisiana Health Insurance Premium Payment (LaHIPP) participants

Children in the LaCHIP Affordable Plan (these recipients will become part of Bayou Health effective January 1, 2013)

Recipients enrolled only for family planning services

III. Carve Outs: Services Excluded from BAYOU HEALTH

When Bayou Health began in the first half of 2012, the following services were not reimbursed as part of the Bayou Health program. They continued to be reimbursed in a fee-for-service environment:

- Pharmacy
- Dental
- Specialized Behavioral Health
- All Hospice
- Targeted Case Management
- Personal Care Services (Children and Adults)
- All Nursing Facility Services
- Individual Education Plan (IEP) Services Billed Through School Districts

Effective November 1, 2012, pharmacy services will be "carved in" to the three prepaid Bayou Health plans. Those three plans are:

- Amerigroup
- LaCare
- Louisiana Healthcare Connections

As a result, pharmacy services will be reimbursed through these plans for the Medicaid and LaCHIP recipients that have joined these three Bayou Health plans.

Medicaid and LaCHIP recipients who joined the two shared savings Bayou Health plans (Community Health Solutions or UnitedHealthcare Community Plan) will continue to have their pharmacy services reimbursed through Louisiana's current legacy Medicaid fee-for-service program.

IV. DHH Guidance to Providers: Dos and Don'ts Related to Recipient Bayou Health Plan Choice

In general, providers are advised to avoid recommending a health plan choice by name to their Medicaid and LaCHIP patients. Providers certainly may identify the health plans that they have joined and explain the benefits and services of those plans.

However, providers are prohibited from recommending specific health plan choices to their patients. Consistent with federal Medicaid regulations, patients choose a health plan with the support (if/as needed) of the independent enrollment broker that has been hired by DHH to provide health plan choice assistance and guidance to Medicaid and LaCHIP recipients.

The following dos and don'ts table describes specific actions that are allowed (but not required) and actions that are not allowed:

Provider "Dos"

Identify for your patients the names of all Health Plans you have joined.

Explain the benefits and services offered to patients by all the Health Plans you have joined.

Display Health Plan participation stickers in your office for all the Health Plans you have joined.

Display and/or distribute health information materials for all Health Plans you have joined.

Provider "Don'ts"

Identify for your patients the names of only some of the Health Plans you have joined.

Explain the benefits and services offered to patients by only some of the Health Plans you have joined.

Display Health Plan participation stickers in your office for only some of the Health Plans you have joined.

Display and/or distribute health information materials for only some of the Health Plans you have joined.

Recommend, encourage, or provide incentives for your patients to select one Health Plan over another.

Guide your patients in their decision to select a Health Plan.

V. Answers to Providers' Frequently Asked Questions

Question:

How do Medicaid and LaCHIP recipients select a Bayou Health plan?

Answer:

Recipients select a Bayou Health plan with the assistance of an unbiased third party enrollment broker that has experience doing this work in many states. Recipients may use any of the following methods to select any one of the five participating health plans:

- Complete the hard copy Enrollment Packet, which includes the Choice Letter, and return by mail or fax.
- Choose a Health Plan by telephone with or without a counselor TOLL FREE at 1-855-BAYOU-4U (1-855-229-6848).
- Choose a Health Plan via website: bayouhealth.com.

Question:

What happens when Medicaid and LaCHIP recipients do not select a Bayou Health plan?

Answer:

The Department of Health and Hospitals (DHH) selects a health plan for eligible recipients who do not select a health plan during their designated enrollment period.

Question:

Does this new Bayou Health plan choice process replace the processes used to A) determine Medicaid and LaCHIP eligibility, and B) complete Medicaid and LaCHIP enrollment?

Answer:

No. The current Medicaid and LaCHIP eligibility and enrollment processes will remain in place. Recipients choose a Health Plan after eligibility is determined and Medicaid and LaCHIP enrollment is completed.

Question:

Do recipients enrolled in a Bayou Health plan still use the current Medicaid and LaCHIP card?

Answer:

Those recipients will have two cards. One is the standard Louisiana Medicaid card. This card can be used by providers to verify (through the Medicaid fiscal intermediary) eligibility and the patient's current Bayou Health plan. The second card will be a health plan card – providers can use information on this card to contact the health plan with questions and problems.

You can identify the health plan of your Medicaid and LaCHIP customers by checking the online Medicaid eligibility verification system (eMEVS). This information tells providers which Bayou Health plan to bill for services or obtain authorizations as needed.

Please note that you should always consider the Medicaid eligibility database the ultimate source of information for Bayou Health plan assignment. A customer may think he or she is in a different plan or may have a letter or ID card from another plan, but the eMEVS information takes precedence.

Question:

How often can patients change BAYOU HEALTH plans?

Answer:

Federal requirements allow patients to change health plans (at will) during the first 90 days of their enrollment. After the 90-day period ends, patients will remain in their chosen health plan. Every BAYOU HEALTH member will have an annual opportunity to change plans. Patients are allowed to change health plans at any time if they have a good reason moving to another area of the state or a change in their health status.

Question:

What is allowed/not allowed for providers when communicating with their Medicaid and LaCHIP patients about BAYOU HEALTH plans?

Answer:

Providers may identify the health plans that they have joined. Providers are not allowed to counsel patients regarding health plan choices or recommend any health plan choices to patients.

Question:

What is the penalty for providers violating one of the provider outreach don'ts (for example: helping our recipients to choose a health plan)?

Answer:

The possible penalties are spelled out in the DHH contracts with the health plans and penalties will be taken against the health plan. DHH will notify the health plan in writing of the determination of the non-compliance, of the penalty that will be imposed, and of any other conditions related such as the length of time the penalty shall continue and of the corrective actions that the health plan must perform.

- DHH may require the health plan to recall the previously authorized marketing material(s);
- DHH may suspend enrollment of new members to the health plan;
- DHH may deduct the amount of capitation payment for members enrolled as a result of non-compliant marketing practices from the next monthly capitation payment made to the health plan and shall continue to deduct such payment until correction of the failure;
- DHH may require the health plan to contact each member who enrolled during the period while the health plan was out of compliance, in order to explain the nature of the non-compliance and inform the member of his or her right to transfer to another health plan; or
- DHH may prohibit future marketing activities by the health plan for an amount of time specified by DHH.

VI. Prepaid Health Plans "Carve In" Pharmacy Services

Effective for dates of service beginning November 1, 2012, pharmacy services are "carved in" to the three prepaid Bayou Health plans. Those three plans are:

- Amerigroup
- LaCare
- Louisiana Healthcare Connections

As a result, pharmacy services delivered on and after November 1, 2012 will be reimbursed through these plans for the Medicaid and LaCHIP recipients that are members of these three Bayou Health plans.

Medicaid and LaCHIP recipients who joined the two shared savings Bayou Health plans (Community Health Solutions or UnitedHealthcare Community Plan) will continue to have their pharmacy services reimbursed through Louisiana's current legacy Medicaid fee-for-service program.

You Must Take Action To Be Enrolled As A Provider

The prepaid health plans and their pharmacy benefit managers (PBMs) have provider network specialists charged with the responsibility of developing their pharmacy provider networks, but you do not have to wait to be contacted. You can contact the health plans through the hotlines below to begin the contracting process:

- Amerigroup (CVS/Caremark): 1-480-391-4623
- LaCare (PerformRx): 1-800-555-5690
- Louisiana Healthcare Connections (USScript): 1-877-690-9330

You can choose to enroll in as many health plans as you wish, and you can remain a legacy Medicaid provider to continue providing pharmacy services to your customers who are not part of Bayou Health or are in the two shared savings Bayou Health plans (Community Health Solutions and United Healthcare Community Plan), which will continue processing claims for pharmacy services through the legacy Medicaid fee-for-service program.

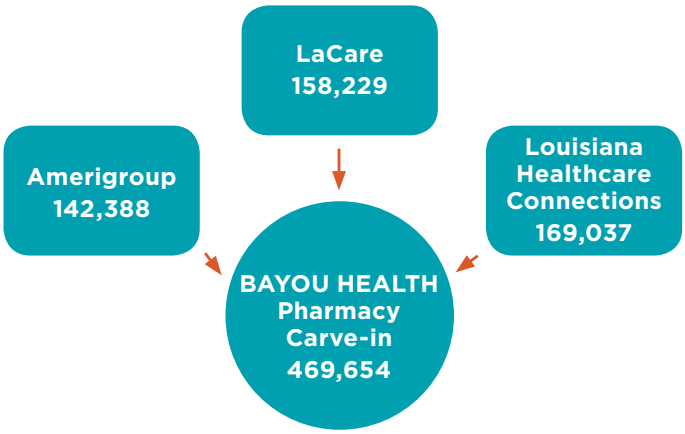
Mail Order Pharmacy

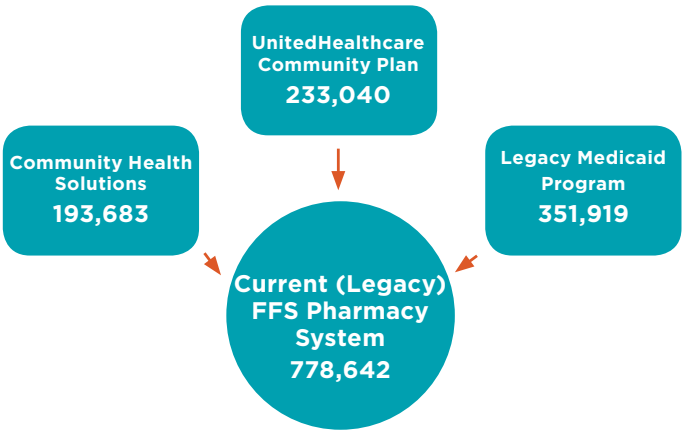
You will not lose business to mail order pharmacy.

Health plans cannot require their members to use a mail service pharmacy. Furthermore, DHH has prohibited health plans from allowing mail order prescriptions to exceed the historical levels used in legacy Medicaid, which are set at one (1) percent of all pharmacy claims in that plan.

Recipient Populations

The following illustration identifies the size of each current (as of September 2012) Bayou Health plan recipient population. The illustration also identifies the size of the current Medicaid and LaCHIP population not enrolled in a Bayou Health plan.





Any Willing Provider

DHH has adopted "any willing provider" language in its rule, meaning that health plans may not deny contracts to any pharmacy currently participating in the Medicaid program. Any pharmacy or pharmacist participating in the Medicaid program may participate as a network provider if they are licensed and in good standing with the Louisiana State Board of Pharmacy and accept the terms and conditions of the contract offered to them by the health plan.

Network Adequacy

Health plans must provide a pharmacy network that complies with DHH requirements but at a minimum includes only licensed and registered pharmacies that conform to the Louisiana Board of Pharmacy rules concerning the records to be maintained by a pharmacy.

Patient access standards include travel distance requirements:

1. Urban areas: Travel distance for members living in urban parishes shall not exceed 10 miles
2. Rural areas: Travel distance for members living in rural parishes shall not exceed 30 miles

Patient Steering and Co-Branding Prohibitions

Health plans will use a PBM to process prescription claims, but the PBMs must pay claims in accordance with the applicable section of the health plan contract, including Bayou Health prompt pay requirements that the plans must pay 90 percent of all clean claims within 15 days, and must pay 99 percent of all clean claims within 30 days. Upon contracting with a provider, the plan must give examples of what constitutes a clean claim so providers can be prepared to bill and receive timely reimbursement for their services.

Health plans are required to identify their PBM and its ownership. The health plan must submit its PBM subcontract to DHH for approval prior to launch. If the PBM is owned wholly or in part by a retail pharmacy provider, chain drug store or pharmaceutical manufacturer, the health plan must submit a written description of the assurances and procedures that will be put in place under the PBM subcontract, such as an independent audit, to prevent patient steering, to ensure no conflicts of interest exist, and ensure the confidentiality of proprietary information.

The health plan must provide a plan documenting how it will monitor such subcontractors. These assurances and procedures must be provided to DHH for review and approval prior to the date pharmacy services begin.

Health plans must submit to DHH for approval a plan for oversight of PBM performance.

DHH will enforce guidelines consistent with Medicare Part-D regarding co-branded PBMs. Health plans are prohibited from displaying the names or logos of co-branded PBMs on the health plan's member identification cards. For any other marketing materials, the health plans are required to include the following language: "Other Pharmacies are Available in Our Network".

Pharmacy Provider Directories

Each health plan must keep an up-to-date pharmacy provider directory on its website for public access. This directory must include, but not be limited to, the following information on all contracted network pharmacies:

1. Names, locations, and telephone numbers
2. Any non-English languages spoken
3. Identification of hours of operation, including identification of providers that are open 24-hours per day
4. Identification of pharmacies that provide vaccine services
5. Identification of pharmacies that provide delivery services

The health plan must make a hard copy of this directory available to its members upon request. The hard copy must be updated at least annually. The online version should be updated in real time, but no less than weekly.

Provider Contracts

Each of the three health plans submitted drafts of the contracts they plan to use to build their network to DHH, which were reviewed and approved to ensure they contain all necessary language and provider protections. Providers are welcome to contract with as many health plans as they wish. The actual contracting process is a negotiation between that provider and a health plan. DHH has provided guidance and contractual review but will not directly negotiate on behalf of any health plan or provider as the plans establish their pharmacy networks.

VII. Notice to Members of Prepaid Plans

The health plans are required to send pharmacy "carve in" information to their members explaining the change and describing what their members must now do when accessing pharmacy services.

Messaging to Members

Members are being advised that starting with dates of service November 1, 2012, if they are enrolled in the Amerigroup, LaCare or Louisiana Healthcare Connections Bayou Health plans, they will now receive their prescription drugs and pharmacy services through their Bayou Health plan.

DHH messaging to those members includes:

> YOU WILL NOT LOSE ANY BENEFITS. YOU CAN KEEP GETTING PHARMACY SERVICES.
>
> Additionally, your health plan must provide you with access to the same types of medicines as your current Medicaid offers. Your Bayou Health plan may offer you additional benefits or let you get more services.
>
> You will still have access to all the same types of medications.
>
> Your health plan has a list of medications that your doctor/medical provider will use to select most of your prescriptions. This list must include the same types of drug classes available through regular Medicaid (A drug class is a group of medications that works the same way or is used to treat the same health condition). This means all types of medicines currently covered by Medicaid will be available from your health plan, but some of the drug names may be different.
>
> If you currently use a prescription that is not on the health plan's list, you will be allowed to continue using that medication if it is medically necessary. If you want to see which prescriptions your health plan will cover, you can call your plan's toll-free member services hotline to ask, or visit your health plan's website to see a list of covered drugs.

Member Co-pays/Cost-Share

Health plans are not required to impose any co-pay or cost sharing requirements on their members. Health plans are not permitted to charge any co-pay or cost-sharing amount above what exists in the Medicaid State Plan.

Medicaid State Plan Co-Payment Schedule

The following is the prescription co-payment schedule:

Calculated State Payment	Co-Payment
$10.00 or less	$0.50
$10.01 to $25.00	$1.00
$25.01 to $50.00	$2.00
$50.01 or more	$3.00

A health plan or its subcontractors may not:

- Deny services to an individual who is eligible for services because of the individual's inability to pay the cost-sharing;
- Restrict its members' access to needed drugs and related pharmaceutical products by requiring that members use mail order pharmacy providers; or
- Impose co-payments for the following:
  - Family planning services and supplies
  - Emergency services
  - Services provided to:
    - ◊ Individuals younger than 21 years old

- ◊ Pregnant women
- ◊ Individuals who are inpatients in long-term care facilities or other institutions
- ◊ Native Americans, and
- ◊ Alaskan Eskimos

Prescriptions Per Month Limits (By Plan)

Louisiana's legacy Medicaid program currently limits the number of prescriptions per person to four a month. The prepaid Bayou Health plans have the flexibility to offer more prescriptions, but cannot offer less than the legacy Medicaid limit. At this point in time, the prepaid health plans do not plan to enforce a monthly prescription limit.

How To Find Pharmacies Enrolled In Each Plan's Network

Members can search their health plan's provider directory online or call the health plan's toll-free member services line to determine what area pharmacies are in their network. Members can also ask their pharmacist which health plans he/she takes.

Plan Member Services Contact Info For Recipients

If members have questions about their pharmacy and prescription drug coverage, they can contact their health plan's member services toll free number or visit the health plan's website.

- Amerigroup
  - Phone: 1-800-600-4441
  - Web: www.myamerigroup.com/la
- LaCare
  - Phone: 1-888-756-0004
  - Web: www.lacarelouisiana.com
- Louisiana Healthcare Connections
  - Phone: 1-866-595-8133
  - Web: www.louisianahealthconnect.com

VIII. Pharmacy Reimbursement

Timely Payment Requirements

Each health plan is required to maintain automated claims and an encounter processing system for pharmacy claims. Health plans are required to meet or exceed contractually set prompt pay requirements or face financial sanctions.

Ninety (90%) percent of all clean claims must be paid within 15 business days, and 99 percent of all clean claims must be paid within 30 calendar days. The health plans are required to offer pharmacy providers examples of what constitutes a clean claim when the provider contracts with a network.

Minimum Dispensing Fee

DHH received tremendous feedback surrounding pharmacy reimbursement. In the Medicaid managed care marketplace, the average generic dispensing fee ranges from $1.75 - $2.00 and the average brand dispensing fee ranges from $1.50 - $1.75. According to DHH's actuaries, no state with managed Medicaid pharmacy has established a rate floor for pharmacy services. However, based on concern and feedback shared by pharmacists across the state, during a series of regional forums in June and through feedback submitted, DHH will require the health plans to pay a per-prescription dispensing fee no less than $2.50.

Ingredient Cost Reimbursement

DHH established a rate floor on dispensing fee, but the ingredient cost reimbursement is a

negotiation between the provider and the health plan, and there will not be a set floor for this element. The health plans are not required to use the Average Acquisition Cost (AAC) based reimbursement methodology implemented for the legacy Medicaid fee-for-service program and have the option of using Average Wholesale Price (AWP) or other reimbursement methodology. When contracting to join a network, providers should be prepared to discuss ingredient cost reimbursement and have their questions answered as part of the negotiation.

Medication Therapy Management

DHH requires the health plans to develop Medication Therapy Management (MTM) programs, that include participation from community pharmacists, and include both in-person and telephonic interventions with trained clinical pharmacists. DHH requires that any reimbursement for MTM services with participating pharmacists be separate and above dispensing and ingredient cost reimbursement.

These programs will be developed to identify and target members who would most benefit from these interactions. They should include coordination among the health plan, the member, the pharmacist, and the prescriber using various means of communication and education.

Claims Processing

Health plans are required to maintain an automated claims and encounter processing system for pharmacy claims that meets current transactions standards, will support the requirements of their contracts, and ensure the accurate and timely processing of claims and encounters. The system shall provide for an automated update to the National Drug Code file, including all product, packaging, prescription, and pricing information. The system shall provide online access to reference file information and maintain a history of the pricing schedules and other significant reference data. The health plans are required to update pricing information based on the most recently available information on at least a weekly basis.

IX. Covered Services

The following information addresses covered pharmacy services.

Transition of Care

Health plans must submit for approval a transition of care program that ensures members can continue treatment of maintenance medications for at least 60 days after launch of pharmacy services or enrollment into the health plan. The health plan must continue any treatment of antidepressants and antipsychotics for at least 90 days after enrollment or launch. Additionally, an enrollee receiving a prescription drug that is not on the health plan's Formulary or PDL shall be permitted to continue to receive that prescription drug if it is medically necessary.

Formulary

Health plans are required to have a Formulary that meets the following minimum requirements:

1. The Formulary must be kept up-to-date and available to all providers and members via health plan website and electronic prescribing tools.

2. The Formulary only excludes coverage of drugs or drug categories permitted under Section 1927(d) of the Social Security Act. In addition, the health plan must include in its formulary any FDA-approved drugs that may allow for clinical improvement or are clinically advantageous for the management of a disease or condition.

3. The Formulary must be reviewed in its entirety and updated at least annually.

4. The health plan must expand its Formulary, as needed, to include drugs that are equivalent to new drugs approved by the FDA, and which are deemed to be appropriate, safe, and efficacious in the medical management of members.

5. The Formulary and any revision must be reviewed and approved by DHH prior to implementation. Any changes to the Formulary must be submitted to DHH at least 30 days prior to implementation.

6. The Formulary must include only FDA-approved drug products. For each Therapeutic Class of drugs, the selection of drugs included for each drug class must be sufficient to ensure enough provider choice and include FDA-approved drugs to best serve the medical needs of members with special needs.

7. The health plan must authorize the provision of a drug not on the Formulary requested by a prescriber on behalf of the enrollee, if the approved prescriber provides relevant clinical information to the health plan to support the medical necessity of the drug. Medically accepted indications shall be consistent with Section 1927(k)(6) of the Social Security Act.

8. The health plan must have in place a DHH-approved prior approval process for authorizing the dispensing of non-Formulary drugs.

9. Except for the use of approved generic drug substitution of brand drugs, under no circumstances shall the health plan permit the therapeutic substitution of a prescribed drug without a prescriber's authorization.

10. The health plan will not be allowed to make negative changes to the Formulary (e.g., remove a drug, impose step therapy, etc.) more than four times annually, unless urgent circumstances require more timely action, such as drug manufacturer's removal of a drug from the market due to patient safety concerns.

PREFERRED DRUG LIST (PDL)

Health plans may use a preferred drug list (PDL) as long as the requirements of covered services and the following minimum requirements are met:

1. The PDL is a subset of preferred drug products available on the Formulary and an up-to-date version is available to all providers and members through the health plan website and electronic prescribing tools.

2. The PDL must be reviewed in its entirety and updated at least annually.

3. The PDL and any revision thereto, must be reviewed and approved by DHH prior to implementation. Any changes to the PDL must be submitted to DHH at least 30 days prior to implementation.

4. The selection of drugs included for each drug class must be sufficient to ensure enough provider choice and include FDA-approved drugs to best serve the medical needs of enrollees with special needs.

5. The health plan must authorize the provision of a drug not listed on the PDL requested by a prescriber on behalf of the enrollee, if the approved prescriber provides relevant clinical information to the health plan to support the medical necessity of the drug. Medically accepted indications shall be consistent with Section 1927(k)(6) of the Social Security Act.

6. The health plan must have in place a DHH-approved prior approval process for authorizing the dispensing of non-PDL drugs.

7. Except for the use of approved generic drug substitution of brand drugs, under no circumstances may the health plan permit the therapeutic substitution of a prescribed drug without a prescriber's authorization.

8. The health plan is not be allowed to make negative changes to the PDL (e.g., remove a drug, impose step therapy, etc.) more

than four times annually, unless urgent circumstances require more timely action, such as drug manufacturer's removal of a drug from the market due to patient safety concerns.

Prior Authorization Process

Health plans may utilize a prior authorization process for drug products under the following conditions:

1. When prescribing medically necessary non-Formulary or non-preferred (non PDL) drugs.
2. When prescribing drugs inconsistent with FDA approved labeling, including behavioral health drugs.
3. When prescribing is inconsistent with nationally accepted guidelines.
4. When prescribing brand name medications that have A-rated generic equivalents.
5. To minimize potential drug over-utilization.
6. To accommodate exceptions to Medicaid drug utilization review standards related to proper maintenance drug therapy.

A. Any prior approval issued by the health plan must take into consideration prescription refills related to the original pharmacy service.

B. The health plan must notify the requesting practitioner of the approval or disapproval of the request within 24 hours once relevant medically necessary information is obtained from the prescriber.

C. The health plan must provide access to a toll-free call center for prescribers to call to request prior authorization for non-preferred drugs or drugs that are subject to clinical edits. The health plan must allow prescribers to submit automated prior authorization requests, as well as requests by phone or fax. If the health plan or its PBM operates a separate call center for prior authorization requests, it will be subject to the provider call center standards and monetary penalties set forth in the Bayou Health contract.

D. The health plan must not penalize the prescriber or enrollee, financially or otherwise, for such requests and approvals.

E. Denials of prior authorization requests or offering of an alternative medication must be provided to the prescriber and/or enrollee in writing.

F. An enrollee receiving a prescription drug that was on the health plan's Formulary or PDL and subsequently removed or changed must be permitted to continue to receive that prescription drug if determined to be medically necessary. The health plan must make that determination in consultation with the prescriber.

G. If a prescription for a medication is not filled when the prescription is presented to the pharmacy due to a prior authorization requirement, the health plan must have an automated process that allows the pharmacy to dispense up to a 72-hour supply of a product without having to obtain an override. The pharmacy may fill consecutive 72-hour supplies if the prescriber remains unavailable. The health plan must reimburse the pharmacy for dispensing the temporary supply of medication.

H. A member, or a provider on member's behalf, may appeal prior authorization denials in accordance with the Bayou Health Grievances and Appeals provisions, outlined in the health plan's contract.

The health plan may only restrict or require a prior authorization for prescriptions or pharmacy services prescribed by Mental Health or Substance Abuse (MH/SA) providers if one of the following exceptions is demonstrated:

1. The drug prescribed is not related to the treatment of substance abuse/dependency/addiction or mental illness or to any side effects of the psychopharmacological agents. These drugs are to be prescribed by the health plan's Primary Care Physicians or specialists in the health plan's network.
2. The prescribed drug does not conform to standard rules of the health plan's pharmacy plan.
3. The health plan, at its option, may require a prior authorization (PA) process if the

number of prescriptions written by MH/SA providers for MH/SA-related conditions exceeds four (4) per month per enrollee or are shown to be contraindicated based on the enrollee's medical conditions or other drugs already prescribed. For drugs that require weekly prescriptions, these prescriptions shall be counted as one (1) per month and not as four (4) separate prescriptions.

Step Therapy and/or Fail First Protocols

Health plans are allowed to implement step therapy or fail first protocols to first drive utilization toward the most cost-effective and safest drug therapy. These protocols may be applied to either individual drugs or classes of drugs.

However, the health plan must provide a clear process for a provider to request an override of such restrictions. At a minimum, the health plan should grant the override when the prescribing physician provides evidence that the preferred treatment method has been ineffective in the treatment of the patient's medical condition in the past or will cause or will likely cause an adverse reaction or other physical harm to the patient.

Drug Utilization Review (DUR) Program

Health plans must establish and maintain a drug utilization review (DUR) program that satisfies the minimum requirements for prospective and retrospective DUR as described in Section 1927(g) of the Social Security Act. The health plan shall include review of MH/SA drugs in its DUR program.

1. DUR standards shall encourage proper drug utilization by ensuring maximum compliance, minimizing potential fraud and abuse, and taking into consideration both the quality and cost of the pharmacy benefit.
2. The health plan must implement an online claims adjudication system, which shall include a prospective review of drug utilization, and include age-specific edits where appropriate.
3. The prospective and retrospective DUR standards established by the health plan must be consistent with those same standards established by fee-for-service Medicaid program.
4. The health plan's DUR program must include the standards for each category of DUR, (e.g., therapeutic duplication, drug-drug interaction, maximum daily dosage and therapy duration).
5. The health plan's DUR program must include a procedure/process for utilization review for each category of DUR.
6. DHH will review and approve the health plan's DUR policy and procedures; DUR utilization review process/procedure and the standards included therein; and any revisions. The DUR program and revisions must be submitted to DHH for prior approval in advance of the effective date. The health plans must make DUR information available via their websites and by request to plan members or providers in their networks.

Lock-in Program

Health plans may implement a restriction program including policies, procedures, and criteria for establishing the need for the lock-in, which must be prior approved by DHH. The lock-in program must meet guidelines similar to the current Medicaid lock-in program.

Lock-in is a mechanism for restricting Medicaid recipients to a specific physician and/or a specific pharmacy provider. The lock-in mechanism does not prohibit the recipient from receiving services from providers who offer services other than physician and pharmacy benefits.

X. Specialty Drugs and Specialty Pharmacies

DHH recognizes the importance of providing adequate access to specialty drugs to Medicaid members while ensuring proper management of handling and utilization. For the purposes of this program, "specialty drugs" shall be determined by the definition below. Health plans may limit distribution of specialty drugs from a network of specialty pharmacies that meet the requirements to distribute specialty drugs and are willing to accept the terms of the health plan's agreement.

Specialty drug defined

A specialty drug is defined as follows:

1. The drug is not typically available at community retail pharmacies or under limited distribution per manufacturer/FDA; or
2. The drug includes at least two of the following characteristics:
    a. Requires inventory management controls including but not limited to unique storage specifications, short shelf life, and special handling; or
    b. Must be administered, infused or injected by a health care professional; or
    c. The drug is indicated primarily for the treatment or prevention of:
        i. A complex or chronic medical condition, defined as a physical, behavioral or developmental condition that may have no known cure and/or is progressive and/or can be debilitating or fatal if left untreated or under-treated, such as, but not limited to, multiple sclerosis, hepatitis C, cancer and rheumatoid arthritis; or
        ii. A rare medical condition, defined as any disease or condition that typically affects fewer than 200,000 people in the United States.
    d. The total monthly cost is $3,000 or more.

XI. Transparency and Reporting

DHH contracts with the health plans include a full range of transparency and reporting requirements, including the following pharmacy-specific items.

Pharmaceutical and Therapeutics (P&T) Committee

Health plans are required to establish a Pharmaceutical and Therapeutics (P&T) Committee, or similar entity, for the development of the Formulary and Preferred Drug List (PDL). Health plans must ensure that Louisiana network physicians, pharmacists, dentists, and specialists have the opportunity to participate in the development of the Formulary, PDL, and clinical drug policies and, prior to any changes to the Formulary or PDL, to review, consider, and comment on proposed changes.

The P&T committee must meet at least biannually to consider products in categories recommended for consideration for inclusion/exclusion on the health plan's Formulary or PDL. In developing its recommendations for a Formulary and PDL, the P&T committee must consider, for each product included in a category of products, the clinical efficacy, safety, cost-effectiveness, and any program benefit associated with the product.

Health plans must develop policies governing the conduct of P&T committee meetings, including procedures by which it makes its Formulary and PDL recommendations. P&T Committee meetings must be open to the public.

Financial Disclosures for Pharmacy Services

Health plans must disclose to DHH all financial terms and arrangements of any kind that apply between the health plan and any prescription drug manufacturer or labeler, including, without limitation, formulary management, educational support, claims processing, pharmacy network fees, data sales fees, and any other fees. Health plan contracts provide that DHH or state auditors may audit such information at any time.

Rebates

Health plans will be required to submit all pharmacy encounters, with the exception of inpatient hospital pharmacy encounters, to DHH. Then DHH or its vendor will submit these pharmacy encounters for rebate from manufacturers. In addition to the monetary sanctions outlined in the health plan contract, failure of the health plan to submit monthly pharmacy encounter claims files and/or a response file to any disputed encounters within 60 calendar days will result in a quarterly offset to the capitation payment equal to the value of the rebate assessed on the disputed encounters being deducted from the health plan's capitation payment.

Repackaged Products

DHH requires that the health plans follow rules consistent with repackaging requirements in the current legacy Medicaid pharmacy program. Health plans are required to ensure that the manufacturer number, product number, and package number for the drug dispensed shall be listed on all claims. Repackaged drug products supplied through co-ops, franchises or other sources not readily available to other providers, are not allowed to be used. In such instances, the manufacturer number, product number, and package number for the largest package size, as reported in one or more national compendia for the drug, shall be listed.

Required Reports

DHH is adding reporting requirements to existing health plan contract requirements, including, but not limited to:

- Pharmacy help desk performance
- Prior authorization performance
  - Request turnaround
  - 72-hour emergency supply
  - Denials
- Pharmacy network access
- Pharmacy grievances and appeals

XII. DHH Support Information

You can learn more about the Bayou Health pharmacy program by visiting www.MakingMedicaidBetter.com and clicking on the "Pharmacy" tab. This website also contains information about how you can contact the provider relations staff at any of the Bayou Health plans for swift resolution of issues and so you can escalate problems as needed. These staff can help you address any issues you are encountering specific to that health plan.

DHH's Bayou Health team is also available to answer any questions and provide assistance through this process. You can email any questions or comments to BayouHealth@la.gov and staff will respond. Bayou Health is typically able to provide an answer within one business day.

Providers should also sign up for the Bayou Health electronic newsletter to receive frequent email updates on the progress of pharmacy inclusion and other initiatives. Providers can sign up at www.MakingMedicaidBetter.com and use the "Subscribe to Newsletter" button on the homepage, or you can email BayouHealth@la.gov and ask to be included on the newsletter email list.

Bayou Health has modified its daily provider call schedule to focus on pharmacy questions and comments. All calls take place from noon to 1:00 p.m. and are tailored to address specific issues as follows:

- Monday – Primary Focus on Pharmacy Questions and Comments
- Tuesday – Primary Focus on Pharmacy Questions and Comments
- Wednesday – Hospitals, Physicians, and other providers
- Friday – Primary Focus on Pharmacy Questions and Comments

The call-in information (pre-registration is not required) is:
Call-in #: 1-888-278-0296
Access Code: 6556479#

Thursday's calls focus on specialized behavioral health services, and are conducted through Magellan/Louisiana Behavioral Health Partnership. The call-in information for this call is:

Call-in #: 1-888-205-5513
Access Code: 827176

Any provider is welcome to call on any of the days, but Bayou Health staff will give priority to questions from the designated provider type for that call, and will have staff who work in that provider area on the line to assist.